

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CASE PROGRESS REPORT

☐ Initial ☐ Supplement ☐ Final ☐ Reopened

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYER	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment

B. PAYMENT TYPE

Enter actual amounts paid

	RATE	WEEKS	DAYS	TOTAL PAYMENTS
<input type="checkbox"/> (a) Temporary Total				
<input type="checkbox"/> (b) Temporary Partial				
<input type="checkbox"/> (c) Permanent Partial				
<input type="checkbox"/> (d) Death				
<input type="checkbox"/> (e) Stipulation/Settlement				
<input type="checkbox"/> (f) Advances				

C. PAYMENTS

TOTAL LOST TIME PAYMENTS TO DATE

1	Total Weekly Benefits	
2	Physician Benefits	
3	Hospital Benefits	
4	Pharmacy Benefits	
5	Physical Therapy	
6	Chiropractic	
7	Other (Medical)	
8	Rehabilitation / Vocational (excluding all of the above)	
9	Late Payment Penalties	
10	Assessed Attorney's Fees	
11	Burial	
Totals		

D. Remarks:

E. ☐ I certify that the total payments are as correct as the available information indicates.

Type or Print Name	Signature	Date
Address	Phone Number	
	E-mail	
Insurer/Self Insurer Name	Claims Office Name	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwgc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).